

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17982

1. PLACE OF DEATH

County..... Registration District No. 701
Township..... Primary Registration District No. 1000
City St. Louis (No. ISOLATION HOSPITAL)

File No.....
Registered No. 5131
St. 24th Ward

2. FULL NAME

Margaret B. Crouse
(a) Residence. No. 1362 Bayard St., 12 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. ~~MARRIED~~, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles Crouse

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7 - 1869

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
60 10 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work nil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) American
(STATE OR COUNTRY)

10. NAME OF FATHER Patrick Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Jane Burnside

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

14. INFORMANT e. Sheridan
(Address) ISOLATION HOSPITAL

15. FILED MAY 26 1930
REGISTRAR L. C. St. Louis

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1930

17. I HEREBY CERTIFY, That I attended deceased from May 16 1930, to May 25 1930 that I last saw h. alive on May 25 1930 and that death occurred, on the date stated above, at 6:10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Erysipelas of leg
Refuse Unknown
15 d.
9? A (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Automyocarditis
(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT WAS THE CONFIRMED DIAGNOSIS?
(Signed) W. H. Bopp, M. D.

5-25-30 (Address) ISOLATION HOSPITAL

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Calvary Cemetery May 27 1930

20. UNDERTAKER ADDRESS

Louis H. Bopp. Kirkwood, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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WRITE FOR

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